

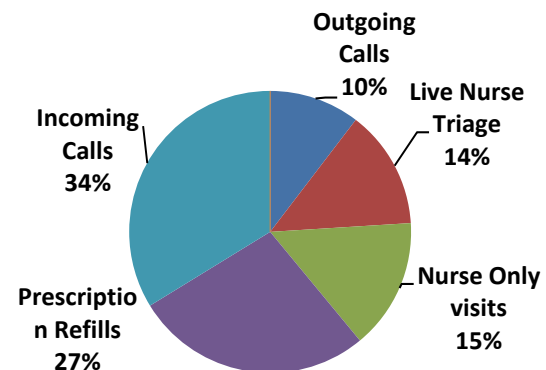
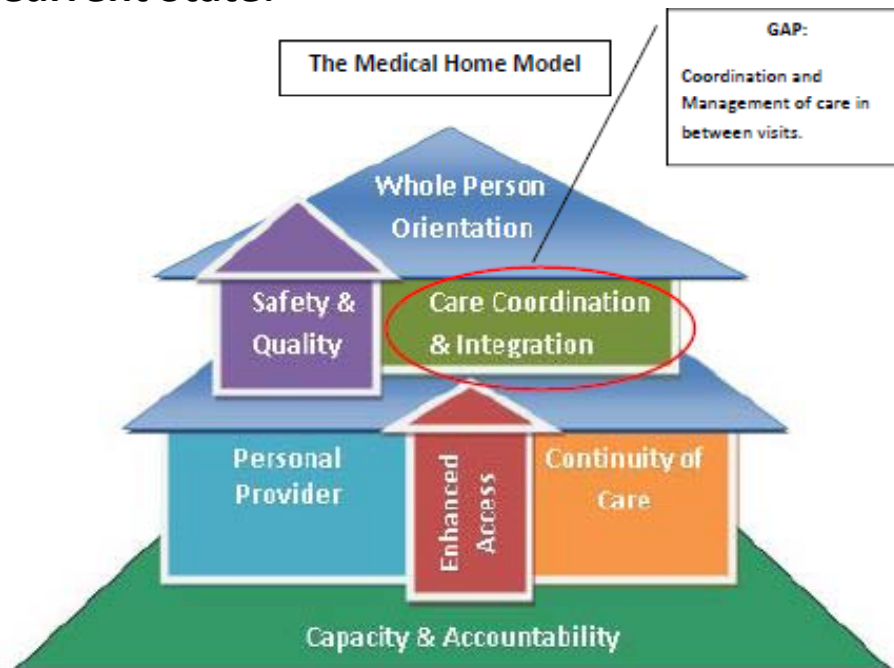
# **Care Manager Role Redesign Project**

**Heather M Marstiller**

# Care Manager Role Redesign

- **Background :** The Patient Centered Medical Home model has a strong emphasis on Care Management activity. The current burdens on the Care Team have not allowed time or focus on care coordination and care management.
- **Business Care:** The anticipated move to value based reimbursement and shared savings will create a need to provide more holistic care in the primary care setting to include, an emphasis on prevention and care coordination.
- **Problem:** Due to the competing demands and burdens, the Care Teams have not had capacity and has not been a priority to focus efforts on the proactive care management and care coordination.

## Current State:

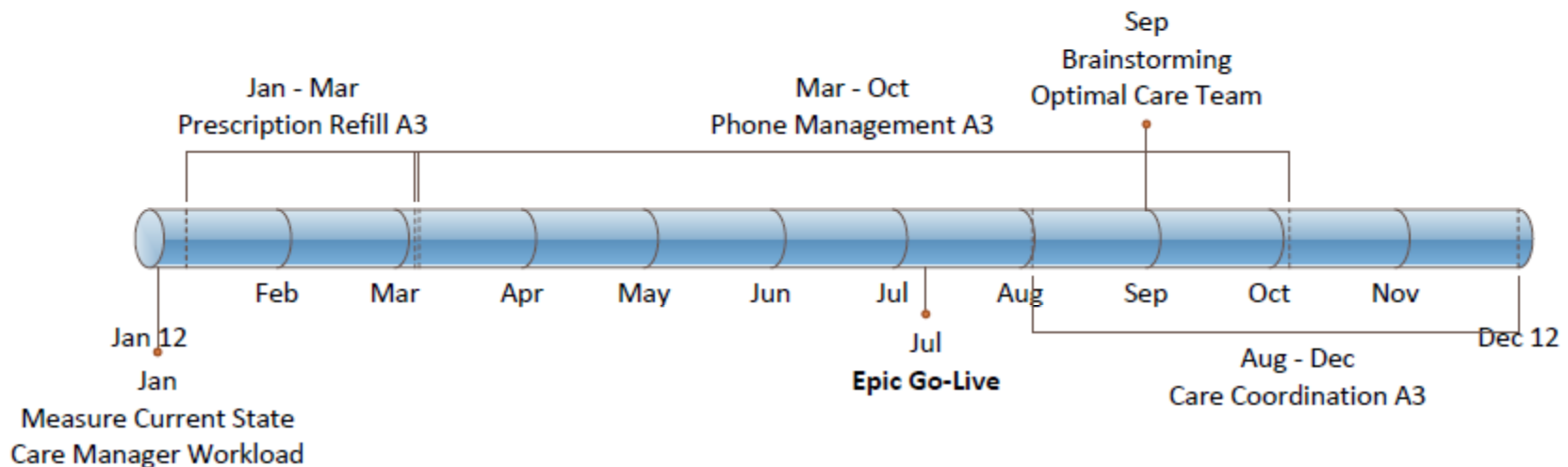


## Who is going to do the work?

**Current Care Manager :** No capacity to do additional care management & care coordination work.

**Goal:** Design Care Management Model for a network of primary care practices that focuses on Care Coordination and Chronic Disease Management Activity.

Recommendations	Description
Create capacity in existing Care Management workload	Identify current workload and identify opportunities to reduce waste and create capacity for new work.
Identify Care Team Model	Develop a care team model that supports that ability to function as a medical home.
Design Care Management Model	Develop standard work for Care Team Members in activities related to Care Coordination and disease management.



# Prescription Refills

**Problem Statement:** The long lead time for RX refills leads to patient complaints, duplicate or triplicate requests by the pharmacy (8% of fax volume), and an increased phone volume for care managers. Calls regarding refill requests up 33% of the care manager's phone volume.

## **Current State:**

Average Total Lead Time: 6.5 hours

Total Processing Time: 2.6 mins

% Value Added Time: <1%

Average Rx Requests per Day: 140

## **Goals:**

Reduce Total Lead Time for Prescription Refills to < 2 hours by March 15, 2012

Reduce demand for prescriptions outside of a patient visit by 10% May 1, 2012

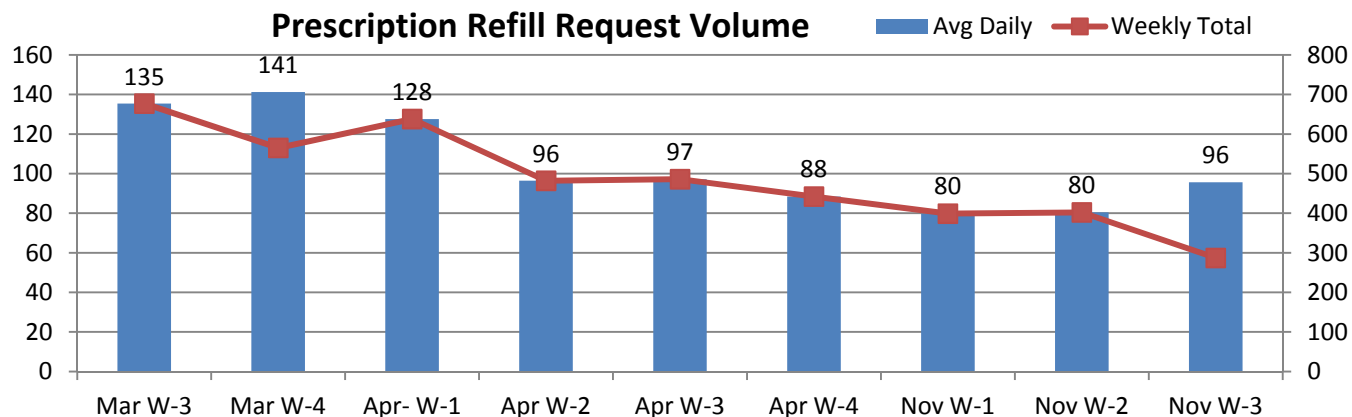
Reduce calls for refill requests by 15% by April 20, 2012

## Analysis and Countermeasures:

Issue	Countermeasure	
No standard for completing refills at the visit	Revise standard rooming work for staff	✓
	Standard work for providers	✓
Concern pts won't return w/ o refill need	Schedule fu appts at visit	✓
Turn around time too long	Create one piece flow for faxed requests	✓
	5S	✓
	Reduce Provider Batches –FUTURE PROJECT	

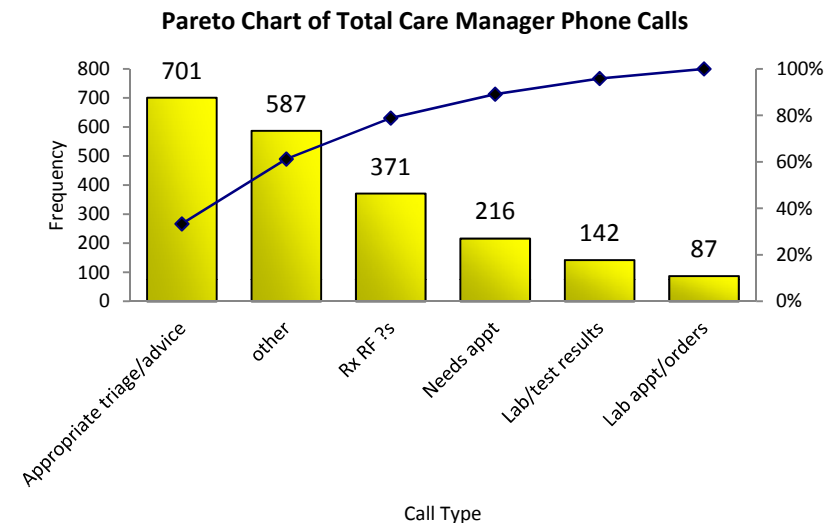
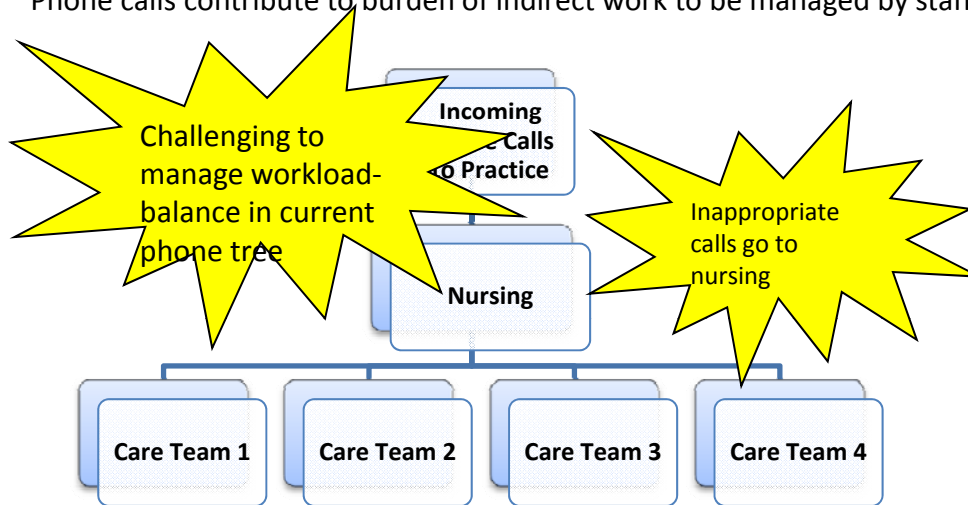
## Outcomes:

- Achieved reduction of Total Lead Time for Prescription Refills to an average of 83 minutes- **Goal Met**
- As of Nov 30th, Rx Refills requests have been reduced by 35% to an average daily demand of 92 a day- **Goal Met**
- Triage calls related to Rx Refills has been reduced to 17.5%- **Goal Met**



# Phone Call Management

**Problem Statement:** Management of incoming phone calls comprises 32% of Care Manager's workday. Care managers' incoming phone volume prohibits their ability to spend time on Care Management activities. Their skill sets are underutilized in this capacity. Phone calls contribute to burden of indirect work to be managed by staff and providers.

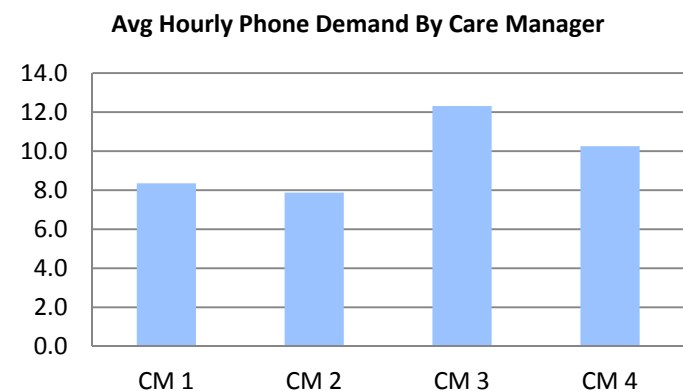


## Triage Line Phone Statistics:

**Average Time to Answer:** 53 seconds

**Average Length of Call:** 2 minutes

**Abandonment Rate:** 12.5%



## Goals:

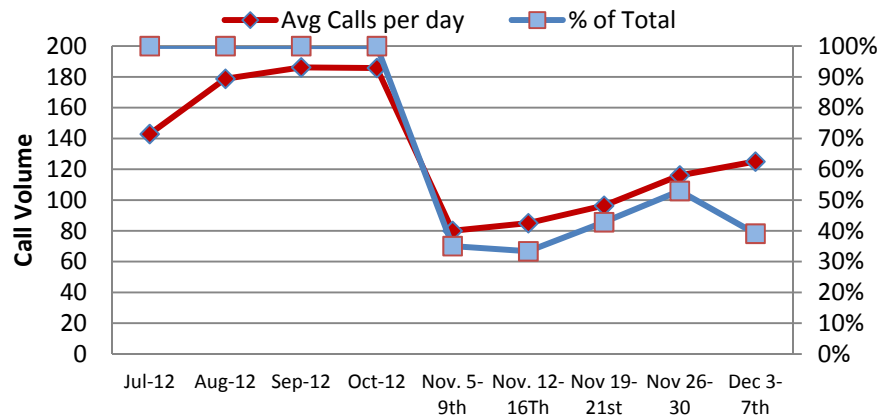
- Reduce inappropriate call volume to care managers by 35% by December 2012.
- Improve Average Time to Answer on the Triage Line by 20 secs by December 2012
- Improve Abandonment Rate on the Triage Line to <10% by December 2012

## Analysis & Countermeasures:

Cause	Countermeasure	
Immunization Record Requests going to Triage	Give Medical Records Access to NCIR	✓
Miscellaneous Calls	Create standards around handling of miscellaneous phone calls	✓
Reduce calls to schedule lab appts	Front desk schedules schedule lab appointments	✓
Phone volume not evenly distributed among CMs	Change phone tree to 1 line, first come/first serve model	✓
★ Misc Calls & Appt Calls	Shift Care Team format. Move PSAs to filter triage phone line. Realign PSA work.	✓
CMs receiving Appt Calls	CMs transfer call s back to Appts	✓

## Outcomes:

Count of Calls Handled By Triage Nurses & % of Total Calls



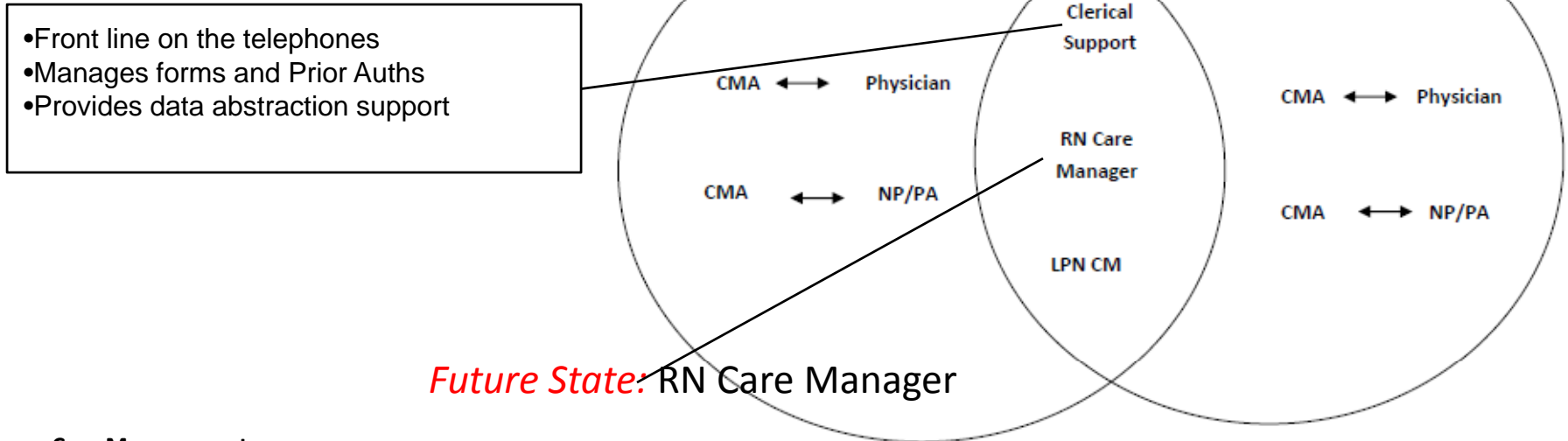
▪Reduced handled calls by avg. of 58% which equates to ~20 work hours per week.

▪95% of calls being handled by nursing are appropriate.

▪Time to answer: 14 secs

▪Abandonment Rate: 3%

## Ideal Care Team Construct



### Care Management:

- Tracks and manages High Risk population
- Works w/ and educates patients to promote self-care
- Conducts post visit follow up as indicated by PCP
- Conducts nurse visits during OFV or Between OFVs
- Identifies high risk patients using risk stratification tool
- Collaborates w/ community resources and other care team members.

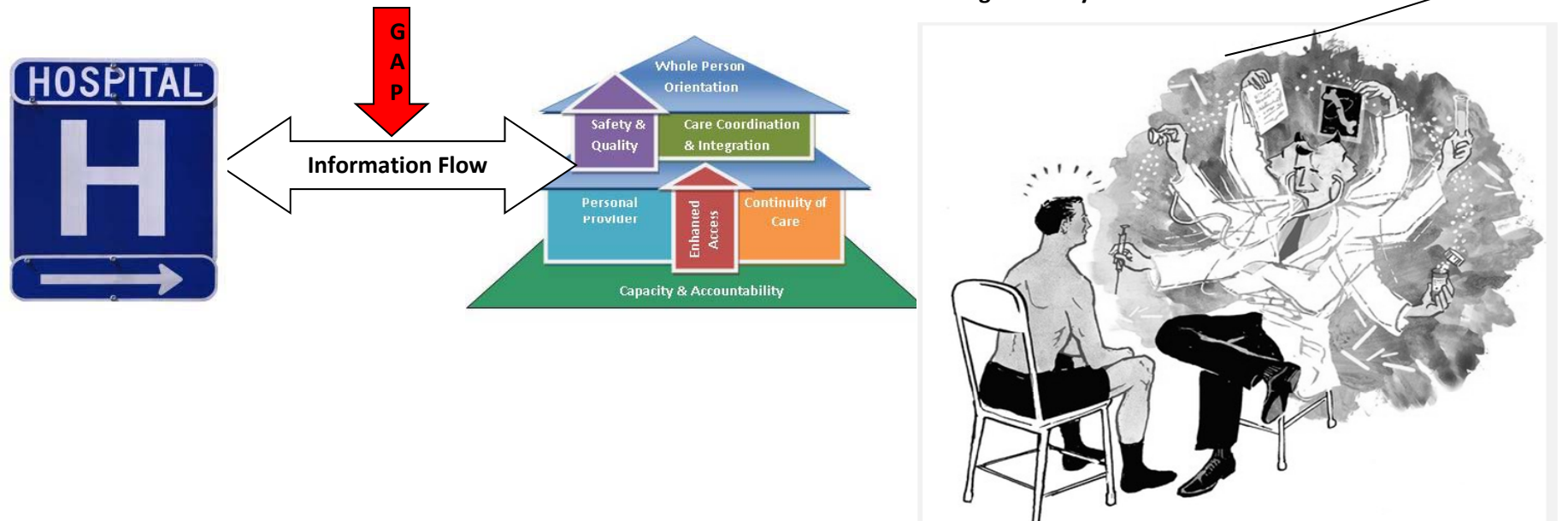
### Care Coordination and Transitions:

- FU w/ pts within 48 hrs of hospital D/C.
- Coordinates w/ other Care Managers, Case Managers, and Post Acute Care Services
- Reviews d/c plans, medications, services, identifies and reviews Red Flags w/ patient
- Assures appt w/in 3-5 days.
- Follows up w/ patient post follow up office visit. Reviews goals, red flags and ongoing care plan.



## Care Coordination: Care Transitions

- **Background :** Transitions out of hospitals and emergency departments back to primary care create opportunities for gaps in proper care and lack of critical information related to patient care. Poorly managed transitions can cause harm to the patient health and well-being and cost the health system money.
- **Problem Statement:** A properly designed transition model has not been developed at DPC Henderson thereby causing an increased burden of work on the providers and potential risk to the patient's health and well-being.



**GOALS:**

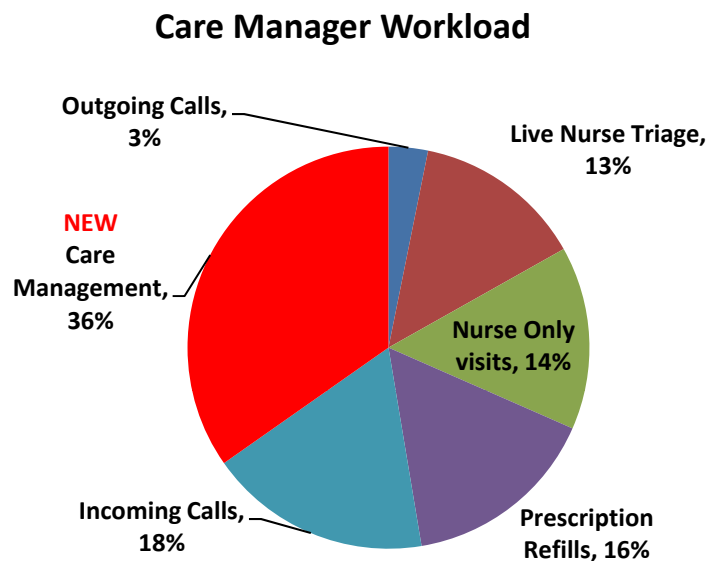
- Develop and implement a Care Transitions model for Hospitalizations and ED back to PCP visits by December 17, 2012
- 90% of hospitalized patients have an appointment with their PCP within 5 days post hospital discharge by January 15, 2013
- 75% of discharged patients have pre-visit contact w/ Care Manager by January 1, 2013
- Reduce avoidable 30 day readmission rates by 1% by July 2013. Baseline 14%.

Issue	Countermeasure	
Weekly census received but not adequate	Collaborate with local hospital on enhancement of notification process	✓
Do not have an ED notification process	Collaborate with local hospital on enhancement of notification process	✓
Do not have information needed to prepare for visit	Collaborate with local hospital on refinement of discharge handoff	✓
Do not have a defined process for follow up visit preparation	Develop standard process for follow up visit prep- flow charts developed	✓
Resources not defined to assist with Transition needs	Collaborate w/ Medicaid Care Managers on Community resources and assistance with transition training for CMs	✓
	Develop Care Management role in transitions- establish RN CM role	✓

**Outcomes to Date:**

- RN hired in currently in training
- Discharge notifications being received daily.
- 85% of discharged patients are receiving post-discharge phone calls as of November 30<sup>th</sup>.
- LPN- Care Managers are piloting Diabetic Outreach calls

## Outcomes to Date:



- **Reduced Work Time on Rx Refills: 10%**
- **Reduced Time on Phone: 26%**
- **Created capacity for new Care Management Work: ~1.4 FTE available time**
- **Realigned Care Team, replacing 1 vacant LPN position with an RN. 1 FTE dedicated to Care Management**
- **LPN Care Managers Piloting Diabetes Outreach Care Management Calls**
- **Happier Care Managers!**

## Next Steps & Follow Up

- Initiate Care Transitions Pilot once RN is fully trained
- Implement Tier 2 Huddle
- Initiate Care Management A3 to develop next phase of Care Management work
- Evaluate Care Management structure and next steps based Health System Care Management Strategy